

4500 N. LEWIS AVE
SIOUX FALLS, SD 57104

F#: (605) 606-0402 P#: (855) 346 7763

Patient Name: Test, Avel
DOB: 03/18/1985 **Sex:** Male

Facility: Rapid City, SD - Rapid City (Monument Health)

Nursing Documentation

General Info

Arrival time to Emergency

Department

04/05/2024 19:23

Time

Zone

Central (CST)

Assessment start time

04/05/2024 19:23

Time Zone (Document in

CST)

Central (CST)

Hold Status at Time of

Assessment

None

Mental Hold

Details

No Mental Health Hold

Arrival

Mode

Private Vehicle

Bedside report:

Patient arrived to the emergency department with spouse. Patient had reported suicidal ideation. Patient has been cooperative in the emergency department. He has received no medications. He is not on psychiatric medications and no outpatient therapy at this time. Spouse remains at bedside.

Is patient prescribed psychiatric medication?

No

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Medications: Non-verified, Medications are per patient or nursing report

None

Medication Compliance Details

Not Applicable

Report

Patient states he has been stressed by work and conflict with spouse. States that he started to have suicidal thoughts and told his spouse about this thoughts and she brought him to the emergency department.

Precipitating Events / Stressors

1. Conflict with Spouse after recent move to a new state
2. Stressed by work; recently got a promotion but he has conflict with new spouse

Psychiatric Diagnosis

Denies current or past diagnosis

Psychiatric Dx Details

Denies

Was collateral obtained

No

Review of Symptoms

Self-Harm

Denies

Homicide

No Thought/Plan/Intent


Violence

No Violence Thought/Plan/Intent

Abuse Issues

Denies abuse

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Psychological Trauma

Have you experienced a traumatic event?

Have you experienced a traumatic event?

Yes

Traumatic event

Car Accident 3 Years ago and passenger passed away

Diagnosed with PTSD related to this event

No

Related to that event, in the past month, have you...

Had nightmares about the event(s) or thought about the event(s) when you did not want to?

Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

Been constantly on guard, watchful, or easily startled?

Had nightmares about the event(s) or thought about the event(s) when you did not want to?

Yes

Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

Yes

Been constantly on guard, watchful, or easily startled?

Yes

Felt numb or detached from people, activities, or your surroundings?

No

Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

No

Changes in sleep patterns

no

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(Anhedonia) Lack of interested in activity

No

Feelings of guilt

No

Changes in energy

No

Change in concentration

No

Psychomotor agitation or retardation

Denies

Changes in Appetite

Denies

History

History of cardiac issues

No

History of seizures

No

History of stroke

No

Pregnant or Breast Feeding

No

Non-Psychiatric medications

None

Allergies

NKDA

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**Primary Care
Provider**

Dr. Test

Do you have a psychiatrist

No

**Psychiatrist/Medication
prescriber**

None

**Do you have a counselor or
therapist**

No

Counselor/Therapist's name

None

**Last seen
counselor/therapist**

Not Applicable

**Next appointment with
counselor/therapist**

Not Applicable

**Do you have Case Managemnt / ACT Worker or attend Group
Therapy**

No

**Have you ever been to mental health inpatient or residential
treatment?**

No

**Last inpatient
hospitalization**

None

**Approximate # of inpatient
visits**

0

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In the last 30 days, have you used any of the following substances

Denies Substance Use

Current Withdrawal

Denies withdrawal symptoms

History of

Seizures

No

History of Delirium tremens (DT)

No

Addiction Treatment History with approximate timeline of treatment

Denies

Family & Social

Adult/Minor

Adult

If Adult, are you able to make your own medical decisions?

If Adult, are you able to make your own medical decisions?

Yes

Patient lives with

Spouse/Significant other

Marital Status

Married

Are there known completed suicides in your family

no

Are there known suicide attempts in your family

no

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Is there known mental illness in your family

no

Employment

Full Time

Other employment status

Farmer

Education

High school

Military Status

N/A

Do you have any pending legal charges?

No

If potential for placement, do you have any past charges of sexual assault or aggravated assault?

No

Columbia

Can patient complete the Columbia assessment?

Yes

1) Wish to be dead ->>- Have you wished you were dead or wished you could go to sleep and not wake up?

Yes

2) Current suicidal thoughts ->>- Have you actually had any thoughts of killing yourself?


Yes

3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) ->>- Have you been thinking about how you might do this?

No

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4) Suicidal Intent without Specific Plan ->>- Have you had these thoughts and had some intention of acting on them?

No

5) Suicidal Intent w/ Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*

No

6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? (In the last 30 days)

No

C-SSRS Suicidal Behavior - Lifetime

No

Access to firearms

No

Access to medications

No

Access to Means in Suicidal Plan

N/A - No suicidal plan

Means safety counseling completed

No

Activating events

Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)


RN Csr Treatment History

Not receiving treatment

Internal

Identifies reasons for living

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How many times have you had these thoughts?

(1) Less than once a week

When you have the thoughts how long do they last?

(1) Fleeting - few seconds or minutes

Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?

(1) Deterrents definitely stopped you from attempting suicide

What sort of reasons did you have for thinking about wanting to die or killing yourself?

(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)

Risk stratification

Moderate

MSE

Thought Process

Coherent

Suicidal Ideation

No

Homicidal Ideation

No


Behavior

Cooperative

Appearance

Well Nourished

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Eye

Contact

Good eye contact

Speech

Clear, Non-Pressured

Psychomotor Activity

Normal

Mood

Neutral Mood

Affect

Congruent

Sensorium

Alert

Orientation

Oriented x3

Memory

Grossly Intact

Fund of Knowledge

Age Appropriate

Intelligence

Average

Insight

Good insight

Judgement

Good judgement

Developmental and Cognitive assessment

Patient is able to participate in the assessment

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Safety Plan

Can patient complete the Safety Plan?

Yes

Warning Signs

Conflict with others, isolating more often

Coping Skills

Going for a walk, talking to a friend, watching Friends Episodes

Reasons for Living

Plans for the Future, Spiritual Reasons

Social Support System

Sister, Friend John, Pastor

Crisis and Professional Service

Call My Doctor
Call/Text Crisis Hotline: 988

Safety Plan Collaboration

Individual agrees to remain clean and sober until crisis passes
Individual agrees to call and talk to mental health provider, hotline, 911, or other responsible person in case of crisis
Individual agrees to accept responsibility of this safety plan

Safeguard Your Home Following these simple steps can help protect you or your family member when experiencing a mental health crisis

Firearms: Ask a trusted family member or friend to keep firearms until the situation improves.
Medications: Store all medications in a lock box or locked medicine cabinet. Dispose of unused medications at your local pharmacy.

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Finish

Assessment completed

Yes

Assessment Type

Assessment Evaluation

Assessment Provided

By

Healthcare Professional
Individual/Patient

Assessment completed time

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